State of Iowa
Family and Medical Leave Act (FMLA)
Certification of Health Care Provider

This form must be returned to the employer within 15 calendar days of the request for certification by the employer or an absence that may qualify as FMLA leave.

TO BE COMPLETED BY THE HEALTH CARE PROVIDER (please print or type)

1. Employee Name: _____

2. Patient Name (if other than employee): _____

3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does your patient's condition qualify under any of the categories described?

   Check (√) one ☐ Yes ☐ No

   ☐ #1 ☐ #2 ☐ #3 ☐ #4 ☐ #5 ☐ #6

4. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories: _____

5. Date Condition Commenced: _____

6. Probable Duration of Condition: _____

7. Regimen of prescribed treatment-indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.

   a. By Health Care Provider: _____

   b. By another provider of health services (any provider for which the State's health insurance plans will accept certification that a serious health condition exists): _____

If this certification relates to care for the employee's seriously ill family member, skip items 8, 9 and 10 and proceed to items 11 thru 14 on the reverse side. Otherwise, continue below.

CHECK (√) **YES** OR **NO** IN THE BOXES BELOW, AS APPROPRIATE

	Yes	No	
8.	☐	☐	Is inpatient hospitalization of the employee required?
9.	☐	☐	Is employee able to perform work of any kind?

10. ☐ ☐ Is employee able to perform the essential functions of his or her position? (Answer after reviewing the following statement from employer.)

Essential Functions: _____

FOR CERTIFICATION RELATING TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL **FAMILY MEMBER**, COMPLETE ITEMS 11 THRU 14 BELOW AS THEY APPLY TO THE FAMILY MEMBER.

CHECK (√) **YES** OR **NO** IN THE BOXES BELOW, AS APPROPRIATE

	Yes	No	
11.	☐	☐	Is inpatient hospitalization of the family member (patient) required?
12.	☐	☐	Does (or will) the patient require assistance for basic medical, personal needs, safety or for transportation?
13.	☐	☐	After review of the employee's signed statement (see below), is the employee's presence necessary or would it be beneficial for the care or recovery of the patient? (This may include psychological comfort.)

14. Estimate the period of time care is needed or the employee's presence would be beneficial: _____

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15. **TO BE COMPLETED BY THE EMPLOYEE (please print or type)**

When FMLA Leave is needed to care for a seriously ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided. Include a schedule if leave is to be taken intermittently or on a reduced leave schedule.

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16. **Signature** of Health Care Provider: _____

17. Type of Practice (Field of Specialization, if any): _____

18. Address: _____

19. Telephone Number: (____) _____ 20. Date: _____

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21. Employee Signature: _____ Date: _____

CFN 552-0610 R 7/2000

Attachment: "A Serious Health Condition"

SERIOUS HEALTH CONDITION

A "**Serious Health Condition**" means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity [1] or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

(a) A period of incapacity [1] of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity [1] relating to the same condition), that also involves:

(1) Treatment [2] **two or more times** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by a health care provider; or

(2) Treatment [2] by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment** [3] under the supervision of the health care provider.

3. Pregnancy

Any period of incapacity due to **pregnancy,** or for **prenatal care.**

4. Chronic Conditions Requiring Treatments

A chronic condition which:

(1) Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

(2) Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and

(3) May cause **episodic** rather than a continuing period of incapacity [1] (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

A period of **incapacity**[1] which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under the continuing supervision of, but need not be receiving active treatment by, a health care provider.** Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive **multiple treatments** [2] (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for **restorative surgery** after an accident or other injury, **or** for a condition that **would likely result in a period of incapacity** [1] **of more than three consecutive calendar days in the absence of medical intervention or treatment,** such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

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[1] **"Incapacity,"** for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

[2] Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

[3] A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.